



2000 Old West Chester Pike
Havertown, PA 19083
484-454-8700
Fax: 484-454-8706
Email: cgrc@cgrc.org
www.cgrc.org

Delaware County Truancy and Delinquency
Prevention Partnership Referral Form

Fax completed form to: CGRC Access Center (484) 454-8706

Please provide as much information as possible.
Direct questions to Joe Mack, Coordinator, (484) 454-8700 extension 1502.

Referring person and agency: _____

Phone: () _____ Fax: () _____

Address: _____

Best contact person at school on this child: _____

Phone: () _____ Fax: () _____

Address: _____

Child's Name: _____ DOB: _____ SS#: _____

Ethnicity: _____ Grade: _____ Gender: Male or Female

School District: _____ Child's Current School: _____

Child's current guardian: _____

What is their relationship with the child? _____

Is the child living with this guardian? _____

If not, with whom is the child living? _____

What is their relationship with the child? _____

Guardian's address: _____

Phone: () _____ Alternate Phone: () _____
(Cell or Business)

Child's current address: _____

Phone: () _____ Alternate Phone: () _____
(Cell or Business)

Child's Mother's name: _____

Address: _____

Phone: () _____ Alternate Phone: () _____
(Cell or Business)

Child's Father's name: _____

Address: _____

Phone: () _____ Alternate Phone: () _____
(Cell or Business)

Please identify strengths of the child and the family: _____

Has the child ever had any mental health services, CYS or Juvenile Court involvement, or Truancy Court involvement? _____

Describe dates, services involved, agencies involved, workers involved, and outcomes: _____

Does the child have any upcoming court dates? _____ When? _____

For what issues? _____



Truancy & Delinquency Prevention Referral

Page 2

Describe the child's school attendance currently and in the past – to include total number of absences, total number of illegal absences, and total number of days tardy for the previous academic year, if you wish: _____

Total number of days absent this school year: _____

Total number of illegal absences this school year: _____

Total number of days tardy this school year: _____

Total number of days illegally tardy this school year: _____

Describe the child's behavior at school: _____

Describe the child's behavior at home: _____

Describe interventions the school or other agencies have employed to rectify problem behaviors: _____

Describe contacts with and involvement of parents / guardians: _____

Is the school's Student Assistance Program involved? _____

Has the child received any mental health or drug and alcohol evaluations? _____

What did those evaluations recommend? _____

Does the child have any significant medical issues? _____

Describe: _____

Is the child taking any medications? _____

What and why? _____

Has the child been tested for special education services? _____

Does the child have an IEP? _____

Describe accommodations outlined in the child's IEP (i.e. LS / ES; Part / Full-time; itinerant; behavior plan; etc.): _____

Describe disciplinary actions taken for this child, including number of detentions, ISS, and OSS: _____

Thank you for your time and consideration in making this referral. Please attach any attendance records, report cards, teacher feedback reports, disciplinary write-ups, behavior plans, evaluation reports, IEP's, or other relevant documents to this referral.

Delivery of services to families will depend on the current waiting list and the family's willingness to cooperate. Please inform the child and guardian of this referral and have them sign the attached release for your school or agency. If this is not possible, please mail the attached release with a letter of intent to the client's home. You can call the Coordinator with updated information prior to establishing communication with an assigned Truancy Worker.

CHILD GUIDANCE RESOURCE CENTERS
Authorization for Release of Information

Page 1 of 2

Client Name: _____ Medical Record #: _____

Address: _____

Social Security #: _____ Date of Birth: _____

Authorization:

I hereby authorize Child Guidance Resource Centers to release and disclose my information by mail, email, courier, or fax:

FROM:
CHILD GUIDANCE RESOURCE CENTERS

TO: School / District, Other Agency (specify)

2000 OLD WEST CHESTER PIKE, HAVERTOWN, PA 19083

I hereby authorize Child Guidance Resource Centers to obtain my information by mail, email, courier, or fax:

FROM: School / District, Other Agency (specify)

TO:
CHILD GUIDANCE RESOURCE CENTERS

2000 OLD WEST CHESTER PIKE, HAVERTOWN, PA 19083

Reason for disclosure:

referral continuity of care verbal communication parents records Other _____

Information to be disclosed: (Individual must check each appropriate section)

Mental Health Yes No or Not Applicable

Information released / obtained Psychiatric/Psychological Evaluation(s), Biopsychosocial/Functional Behavior Assessment(s), Medical History, Medication Orders, Discharge Summary

This information will be disclosed from records protected by Pennsylvania State law. Pennsylvania law prohibits further disclosures of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or is authorized by the Confidentiality of HIV Related Information Act. A general authorization for the release of medical or other information is not sufficient for this purpose.

Education Records Yes No or Not Applicable

Information released / obtained IEP, ER, Report Card(s), Daily Academic and Behavioral Goal Sheets, Behavior Plans, Attendance, Disciplinary Records, School Observations, On-going verbal communication

This information will be disclosed from records protected by Pennsylvania State law and the Family Educational Rights and Privacy Act of 1974.

Drug & Alcohol Yes No or Not Applicable

Information released / obtained Dates of Service, Prognosis, Treatment Recommendations, Relapse

This information will be disclosed from records protected by Federal Confidentiality rules (42 CFR Part 2). The Federal rules prohibit the individual or organization identified on this form from making any further disclosures of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Authorization for Release of Information

Page 2 of 2

HIV

Yes

No or Not Applicable

Information released / obtained: Coordination of Care / Clinical Profile

This information will be disclosed from records protected by Pennsylvania State law. Pennsylvania law prohibits further disclosures of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or is authorized by the Confidentiality of HIV Related Information Act. A general authorization for the release of medical or other information is not sufficient for this purpose.

Demographic information

Yes

No or Not Applicable

Specifically: Current Contact Information, address, phone number, ect.

This authorization expires as indicated: From _____ to _____ (not to exceed one year).

I understand that:

- This consent is voluntary. I may refuse to sign this form.
- This authorization may be revoked at any time in writing to the individual / organization identified in this authorization except to the extent that information has already been disclosed. If information has already been disclosed in reliance on this authorization, revoking it will only prevent future disclosure.
- CGRC, its programs, services, employees, officers, and contractors are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized.
- None of the information released will be used to support any criminal charges or conduct an investigation of me, without a court order.
- If I do not sign this form my treatment team may not receive information that could be important to my treatment.
- If I do not sign this form a delay in treatment or an unknown impact on treatment and care can result.

Authorized Signature(s):

Client Signature (if 14 years of age or older)

Date

Parent / Legal Guardian Signature

Date

FOR DRUG AND ALCOHOL TREATMENT PARENT / LEGAL GUARDIAN SIGNATURE IS NOT APPLICABLE UNDER ACT 63

Witness Signature

Date

If individual is physically unable to sign, signature of second witness: _____

THIS AUTHORIZATION IS NOT VALID UNLESS ALL SECTIONS ARE COMPLETED